| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *SHEN-125647799* | *State:* | *Arkansas* |
| *Filing Company:* | *Shenandoah Life Insurance Company* | *State Tracking Number:* | *39240* |
| *Company Tracking Number:* | *FORM 5786-REV. 5/08* | | |
| *TOI:* | *H21 Health - Other* | *Sub-TOI:* | *H21.000 Health - Other* |
| *Product Name:* | *Employer Application for Small Group Insurance* | | |
| *Project Name/Number:* | */* | | |

## Filing at a Glance

Company: Shenandoah Life Insurance Company

| | | |
|---|---|---|
| Product Name: Employer Application for Small Group Insurance | SERFF Tr Num: SHEN-125647799 | State: ArkansasLH |
| TOI: H21 Health - Other | SERFF Status: Closed | State Tr Num: 39240 |
| Sub-TOI: H21.000 Health - Other | Co Tr Num: FORM 5786-REV. 5/08 | State Status: Approved-Closed |
| Filing Type: Form | Co Status: | Reviewer(s): Rosalind Minor |
| | Author: Thomas Mason | Disposition Date: 06/12/2008 |
| | Date Submitted: 06/09/2008 | Disposition Status: Approved-Closed |
| Implementation Date Requested: On Approval | | Implementation Date: |

State Filing Description:

## General Information

| | |
|---|---|
| Project Name: | Status of Filing in Domicile: Pending |
| Project Number: | Date Approved in Domicile: |
| Requested Filing Mode: Review & Approval | Domicile Status Comments: |
| Explanation for Combination/Other: | Market Type: Group |
| Submission Type: New Submission | Group Market Size: Small |
| Overall Rate Impact: | Group Market Type: Employer |
| Filing Status Changed: 06/12/2008 | |
| State Status Changed: 06/12/2008 | Deemer Date: |
| Corresponding Filing Tracking Number: | |

Filing Description:

Re:  Form 5786-Rev. 5/08 - Employer Application for Small Group Insurance

The above-referenced form is filed herewith for approval by the Department.

Form 5786-Rev. 5/08 is a multi-coverage employer base application for an employer size of 2-9 employees and will replace Form 5271-Rev. 12/05 approved on January 5, 2006.  It constitutes the employer application for previously

approved life, dental, and disability products, as well as any subsequently filed and approved product.

The following documentation is also enclosed:

Readability Certification

We trust that you will be in a position to give this filing an early review. If you have any questions or need additional information, please contact Pamela N. Ferguson at (800) 848-5433 or by email at pamela.ferguson@shenlife.com.

## Company and Contact

**Filing Contact Information**

| | |
|---|---|
| Pamela Ferguson, Director, Legal Services | pam.ferguson@shenlife.com |
| P.O. Box 12847 | (800) 848-5433 [Phone] |
| Roanoke, VA 24029 | (540) 857-5987[FAX] |

**Filing Company Information**

| | | |
|---|---|---|
| Shenandoah Life Insurance Company | CoCode: 68845 | State of Domicile: Virginia |
| 2301 Brambleton Ave. SW | Group Code: 891 | Company Type: Life and Health |
| P.O. Box 12847 | | |
| Roanoke, VA 24029 | Group Name: | State ID Number: |
| (800) 848-5433 ext. [Phone] | FEIN Number: 54-0377280 | |
| | --- | |

## Filing Fees

| | |
|---|---|
| Fee Required? | Yes |
| Fee Amount: | $20.00 |
| Retaliatory? | No |
| Fee Explanation: | $20.00 per application form (if filed separately from policy form) x 1 form = $20.00. |
| Per Company: | No |

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|---|---|---|---|
| Shenandoah Life Insurance Company | $20.00 | 06/09/2008 | 20741606 |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *SHEN-125647799* | *State:* | *Arkansas* |
| *Filing Company:* | *Shenandoah Life Insurance Company* | *State Tracking Number:* | *39240* |
| *Company Tracking Number:* | *FORM 5786-REV. 5/08* | | |
| *TOI:* | *H21 Health - Other* | *Sub-TOI:* | *H21.000 Health - Other* |
| *Product Name:* | *Employer Application for Small Group Insurance* | | |
| *Project Name/Number:* | */* | | |

# Correspondence Summary

### Dispositions

| Status | Created By | Created On | Date Submitted |
|---|---|---|---|
| Approved-Closed | Rosalind Minor | 06/12/2008 | 06/12/2008 |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *SHEN-125647799* | *State:* | *Arkansas* |
| *Filing Company:* | *Shenandoah Life Insurance Company* | *State Tracking Number:* | *39240* |
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| *Product Name:* | *Employer Application for Small Group Insurance* | | |
| *Project Name/Number:* | */* | | |

# Disposition

Disposition Date: 06/12/2008
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *SHEN-125647799* | *State:* | *Arkansas* |
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| *TOI:* | *H21 Health - Other* | *Sub-TOI:* | *H21.000 Health - Other* |
| *Product Name:* | *Employer Application for Small Group Insurance* | | |
| *Project Name/Number:* | */* | | |

| Item Type | Item Name | Item Status | Public Access |
|---|---|---|---|
| **Supporting Document** | Certification/Notice | Approved-Closed | Yes |
| **Supporting Document** | Application | Approved-Closed | Yes |
| **Supporting Document** | Health - Actuarial Justification | Approved-Closed | Yes |
| **Supporting Document** | Outline of Coverage | Approved-Closed | Yes |
| **Supporting Document** | Readability Certification | Approved-Closed | Yes |
| **Form** | Employer Application for Small Group Insurance | Approved-Closed | Yes |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *SHEN-125647799* | *State:* | *Arkansas* |
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| *TOI:* | *H21 Health - Other* | *Sub-TOI:* | *H21.000 Health - Other* |
| *Product Name:* | *Employer Application for Small Group Insurance* | | |
| *Project Name/Number:* | */* | | |

# Form Schedule

**Lead Form Number:** Form 5786-Rev. 5/08

| Review Status | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|---|---|---|---|---|---|---|---|
| Approved-Closed | Form 5786-Rev. 5/08 | Application/ Enrollment Form | Employer Application for Small Group Insurance | Initial | | | 5786.pdf |

SHENANDOAH LIFE INSURANCE COMPANY
Post Office Box 12847 Roanoke Virginia 24029 800.848.5433 www.shenlife.com

# EMPLOYER APPLICATION FOR SMALL GROUP INSURANCE

HOME OFFICE USE ONLY: Policy Number _____ Effective Date _____

## GROUP INFORMATION

Employer Name (Legal) _____

Employer Contact (Person To Contact Concerning Coverages) _____

Title _____ Telephone Number _____

E-mail Address _____ Fax Number _____

Address _____ PO Box _____

City _____ State _____ Zip Code _____

Nature of Business _____ Years in business _____

Employer Tax ID # _____ SIC Code _____

[ ] Proprietorship [ ] Partnership [ ] Corporation

Will this insurance replace existing insurance? ..... [ ] Yes [ ] No

If yes, which coverages are to be replaced? ..... [ ] Life/AD&D [ ] STD [ ] LTD [ ] Vision [ ] Dental

Name of carrier being replaced _____

Effective date _____ Termination date _____

Number of eligible employees working a minimum of 30 hours per week .. _____

If minimum number of hours is greater than 30, list ..... _____

Participation requirement: 2-5 employees - 100% participation
6-9 employees - 100% participation if employer paid.
All but one must participate if employee contributes.

Eligibility Waiting Period:

Current Employees: ..... _____ Days

Subsequent Employees: ..... _____ Days (minimum 30)

For salary-based plans, all changes in amounts of insurance due to salary changes will occur:

[ ] coincident with salary change [ ] on _____ of each year.

Requested effective date: _____

Unless otherwise requested, the policy's effective date will be the first of the month following written acceptance by Shenandoah Life Insurance Company. *Please note*: persons requiring evidence of insurability will not be insured under the plan until Shenandoah Life has approved them individually. *Important*: If this coverage is replacing existing coverage, the existing coverage should not be terminated until you have received written confirmation of coverage(s) from Shenandoah Life.

Premiums are to be paid ..... [ ] Monthly [ ] Other _____

**continued on reverse**

## COVERAGES

[ ] **LIFE & ACCIDENTAL DEATH & DISMEMBERMENT -** *Requires participation in Shenandoah Group Insurance Trust and completion of Form 5280*

Plan Selection (All choices include matching AD&D Benefits)

[ ] Flat Amount

| | |
|---|---|
| [ ] $10,000 | [ ] $50,000 |
| [ ] $15,000 | [ ] $75,000 |
| [ ] $20,000 | [ ] $100,000 |
| [ ] $25,000 | [ ] $150,000 |
| [ ] $30,000 | |

[ ] Multiple of Salary

| Salary Multiple | Maximum Benefit |
|---|---|
| [ ] 1X | [ ] $50,000 |
| [ ] 2X | [ ] $100,000 |
| [ ] 3X | [ ] $150,000 |

Percent of premium paid by employer ..... _____%

[ ] **SHORT TERM DISABILITY**

Benefit Percentage: ..... [ ] 50% [ ] 60%

Weekly Maximum: ..... [ ] $250 [ ] $350 [ ] $500 [ ] $750 [ ] $1,000

Benefit Duration: ..... [ ] 13 weeks [ ] 26 weeks

Benefits begin on _____ day for injury and _____ day for sickness

Percent of premium paid by employer ..... _____%

[ ] **LONG TERM DISABILITY**

Benefit Percentage: ..... [ ] 50% [ ] 60%

Monthly Maximum: ..... [ ] $3,000 [ ] $5,000 [ ] $6,000

Elimination Period: ..... [ ] 90 days [ ] 180 days

Percent of premium paid by employer ..... _____%

[ ] **VISION**

Plan Selection: ..... [ ] Platinum [ ] Gold [ ] Other _____

Percent of premium paid by employer ..... _____%

[ ] **DENTAL**

Annual Deductible: ..... [ ] $25 [ ] $50

Annual Maximum: ..... [ ] $750 [ ] $1,000 [ ] $1,200 [ ] $1,500

Coinsurance: ..... [ ] 100/80/0 [ ] 100/80/50 [ ] 100/90/60 IN, 100/80/50 OON

Endodontics/Periodontics: ..... [ ] Type II [ ] Type III

Benefit Basis: ..... [ ] 80th percentile [ ] 90th percentile [ ] Negotiated Fee

Orthodontia: ..... [ ] $0 [ ] $750 [ ] $1,000

Percent of employee premium paid by employer ..... _____%

Percent of dependent premium paid by employer ..... _____%

Special Remarks _____

_____

_____

_____

_____

## STATEMENT OF UNDERSTANDING

It is understood and agreed that the policy, if issued, shall include the premium rates and administration provisions applicable to the insurance; that such premium rates and administrative provisions shall be binding upon the Applicant and the Company subject to all of the provisions of the policy.

**Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals information for the purpose of misleading, concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.**

*The following states require that alternate statements regarding insurance fraud be given. If you are a resident of any of the following states, please consider the following statements as replacements for the above statement.*

**DC – It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.**

**Florida – Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.**

**New Jersey – Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.**

**Pennsylvania – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.**

**Tennessee – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.**

**Virginia – Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.**

Insurance is subject to the approval of Shenandoah Life Insurance Company and nothing contained herein shall be binding upon Shenandoah Life until this application is approved and accepted at Shenandoah Life's Home Office.

I certify that every eligible employee has been advised of their opportunity to apply for coverage under this policy. Each eligible employee has been advised that in the event that they decline coverage at this time but desire to enroll at a later date, they will be required to furnish evidence of insurability at their own expense and the Company will have the right to refuse any request. To the extent possible, signed enrollment cards have been obtained from every eligible employee, including those declining coverage.

I, the undersigned authorized representative, certify all statements are true and complete to the best of my knowledge and belief.

## SIGNATURES

**AUTHORIZED REPRESENTATIVE OF POLICYHOLDER**

Name (please print) _____

Signature _____ Title _____

Witness _____

Dated at _____ this _____ day of _____, 20____

**AGENT**

Agent/Broker Name (please print) _____

Telephone _____

Do you have knowledge or reason to believe that replacement of prior coverage could be involved?

[ ] No [ ] Yes Which coverages? _____

Agent Signature _____

(Florida agents must show state license number) _____

Address _____ City _____ State _____ Zip _____

**SPECIAL MARKETING AGENT/MARKETING DIRECTOR**

Name (please print) _____

**MARKETING PARTNER**

Name (please print) _____

**SHENANDOAH REGIONAL SALES MANAGER**

Name (please print) _____

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *SHEN-125647799* | *State:* | *Arkansas* |
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| *Product Name:* | *Employer Application for Small Group Insurance* | | |
| *Project Name/Number:* | */* | | |

# Rate Information

Rate data does NOT apply to filing.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *SHEN-125647799* | *State:* | *Arkansas* |
| *Filing Company:* | *Shenandoah Life Insurance Company* | *State Tracking Number:* | *39240* |
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| *TOI:* | *H21 Health - Other* | *Sub-TOI:* | *H21.000 Health - Other* |
| *Product Name:* | *Employer Application for Small Group Insurance* | | |
| *Project Name/Number:* | */* | | |

# Supporting Document Schedules

**Review Status:**

**Bypassed -Name:** Certification/Notice — Approved-Closed — 06/12/2008
**Bypass Reason:** Not Applicable
**Comments:**

**Review Status:**

**Satisfied -Name:** Application — Approved-Closed — 06/12/2008
**Comments:**
See Form Schedule tab

**Review Status:**

**Bypassed -Name:** Health - Actuarial Justification — Approved-Closed — 06/12/2008
**Bypass Reason:** Not Applicable
**Comments:**

**Review Status:**

**Bypassed -Name:** Outline of Coverage — Approved-Closed — 06/12/2008
**Bypass Reason:** Not Applicable
**Comments:**

**Review Status:**

**Satisfied -Name:** Readability Certification — Approved-Closed — 06/12/2008
**Comments:**
**Attachment:**
READABILITY CERT.pdf

SHENANDOAH LIFE INSURANCE COMPANY

# READABILITY CERTIFICATION

This is to certify that the form referenced below is in compliance with the readability requirements of your state.

The Flesch Reading Ease Test was applied to the form.

| FORM NUMBER | SENTENCES | WORDS | SYLLABLES | FLESCH SCORE |
|---|---|---|---|---|
| Form 5786-Rev. 5/08 | 22 | 336 | 576 | 46.3 |

Kathleen M. Kronau

Signature of Company Officer

Kathleen M. Kronau
Vice President and General Counsel

Type Name & Title of Person Signing

June 9, 2008

Date